



2023 Ambulatory Surgical Center Annual Report

This is a sample of the online form. Please use this form to gather the information you will need for submitting the online version.

Facility Information

Please complete this report for the previous year no later than January 31, 2024.

This report is a: ☐ New Report ☐ Corrected Report

Name of Facility _____

Address of Facility

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP _____

Reporting Period

Required reporting period is January 1 through December 31, 2023.

Was the facility in operation 12 full months at the end of the period? ☐ Yes ☐ No

If no, please report the number of days in operation. _____

Classification

The following definitions apply to this section of the report:

- **Not for Profit** - Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
- **For Profit (Proprietary)** - Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

Classification ☐ Not for Profit ☐ For Profit

Governmental entity (state, city, county or federal), corporation, company, etc. responsible for the ownership and management of the agency _____

Name of management firm of facility (N/A if management is not provided through contract) _____

Is the facility operated as part of a chain, whether for profit or not? ☐ Yes ☐ No

If Yes, please give name and address of the PARENT organization

Parent organization _____

Parent organization Address _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP _____

Utilization of Suites and Services

Report utilization for a full 12-month period.

Total Number of Procedures performed (Excluding exploratory/diagnostic endoscopies) _____

Total Number of Exploratory/ Diagnostic Endoscopies Performed _____

“Total number of surgical suites” should include the number of suites licensed and certified on the last day of the reporting period. A laser or procedure room not meeting physical plant requirements as an ambulatory surgical center suite should not be included.

Total Number of Surgery Suites _____

Total Number of Patients (Patients should be counted only once for multiple procedures performed during same day visit) _____

Total Number of Patients Transferred to Acute Care Hospital During Report Period _____

Type of Surgery Performed (List 12 most frequently performed)

If there are less than 12 surgeries performed, please enter 0 in remaining fields.

1. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
2. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
3. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
4. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
5. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
6. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
7. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
8. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
9. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
10. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
11. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____
12. Surgery Type _____	CPT CODE Number _____	Number of Procedures Performed _____

Personnel Data

Exclude volunteers and all personnel whose salary is financed entirely by outside research grants. For combined facilities, report **only** the personnel for the ambulatory surgical facility as of December 31, 2022.

Nursing (RN/LPN) - Full Time (35 hrs/wk) _____ Nursing (RN/LPN) - Part Time (<35 hrs/wk) _____

Aides/Technologists - Full Time (35 hrs/wk) _____ Aides/Technologists - Part Time (<35 hrs/wk) _____

Administration - Full Time (35 hrs/wk) _____ Administration - Part Time (<35 hrs/wk) _____

Other - Full Time (35 hrs/wk) _____	Other - Part Time (<35 hrs/wk) _____	
Total Full Time Employees _____	Total Part Time Employees _____	

Financial Data

Report expenses for the full 12-month period. If actual figures are not available, please estimate (indicate which figures are estimated by checking the box after the amount). Round all figures to the nearest dollar. Do not use commas.

Total gross revenue: Includes total revenues from direct patient care and all other sources.

Total Gross Revenue \$ _____ ☐ Estimated?

Payroll expenses: Report salaries for full-time and part-time personnel as reported in Personnel Data Tab.

Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

Payroll Expenses \$ _____ ☐ Estimated?

Non-payroll Expenses \$ _____ ☐ Estimated?

Total Expenses \$ _____

Compare financial data with previous year Annual Report financial data and explain any differences exceeding 10%.

Fiscal year ending date _____

Facility's average cost and average charge from most recent financial statement:

Average cost \$ _____ Average charge \$ _____

Procedures and revenue breakdown by payor source:

MEDICARE Number of Procedures _____	MEDICARE Percent of Operating Revenue _____ %
MEDICAID Number of Procedures _____	MEDICAID Percent of Operating Revenue _____ %
INSURANCE Number of Procedures _____	INSURANCE Percent of Operating Revenue _____ %
PRIVATE PAY Number of Procedures _____	PRIVATE PAY Percent of Operating Revenue _____ %
UNFUNDED Number of Procedures _____	UNFUNDED Percent of Operating Revenue _____ %
OTHER Number of Procedures _____	OTHER Percent of Operating Revenue _____ %
Total number of procedures _____	Total _____ %

Please make sure the Total Percent of Operating Revenue equals 100%.

Patient Origin Data:

Report all patients served by the facility for the reporting year by county of origin. The total **must** equal the total number of patients reported in "Utilization" tab.

Beaverhead	_____	Big Horn	_____	Blaine	_____
Broadwater	_____	Carbon	_____	Carter	_____
Cascade	_____	Chouteau	_____	Custer	_____
Daniels	_____	Dawson	_____	Deer Lodge	_____
Fallon	_____	Fergus	_____	Flathead	_____
Gallatin	_____	Garfield	_____	Glacier	_____
Golden Valley	_____	Granite	_____	Hill	_____
Jefferson	_____	Judith Basin	_____	Lake	_____
Lewis and Clark	_____	Liberty	_____	Lincoln	_____
Madison	_____	McCone	_____	Meagher	_____
Mineral	_____	Missoula	_____	Musselshell	_____
Park	_____	Petroleum	_____	Phillips	_____
Pondera	_____	Powder River	_____	Powell	_____
Prairie	_____	Ravalli	_____	Richland	_____
Roosevelt	_____	Rosebud	_____	Sanders	_____
Sheridan	_____	Silver Bow	_____	Stillwater	_____
Sweet Grass	_____	Teton	_____	Toole	_____
Treasure	_____	Valley	_____	Wheatland	_____
Wibaux	_____	Yellowstone	_____	Unknown/In State	_____
Out of State	_____			Total	_____

Please complete this report no later than January 31, 2024.

Report Completion Data

Date Report Completed _____

Administrator's Name _____ Administrator's Email Address _____

If there are questions about any of the responses to this report, who should be contacted?

Contact Name _____

Contact Phone Number _____ Contact Email _____

If you have any questions, please contact:

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